

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

8775

Registrar's No.

2258

Registration District No.

791

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1905 LaSalle St. 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None (Specify whether
5 yrs years, months or days)

3. (a) PRINT FULL NAME George Click

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married widowed
 6. (b) Name of husband or wife Lucinda 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 29 1854
 (Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Tennessee
 (City, town, or county) (State or foreign country)

10. Usual occupation _____
 11. Industry or business Retired 6 Years
Micheal Click

MOTHER FATHER
 12. Name Micheal Click
 13. Birthplace unknown (City, town, or county) (State or foreign country)
 14. Maiden name Susan Cuttingham
 15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Geo A Click
 (b) Address 1905 LaSalle
 17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar. 7, 1940
 (Month) (Day) (Year)
 (c) Place: burial or cremation union City, Tenn.

18. (a) Signature of funeral director A. W. McHughlin
 (b) Address 2801 Lafayette Ave

19. (a) Mar 7 1940 (b) Geo A Click
 (Received local Registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 22
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1905 LaSalle St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 6
 year 1940 hour 9²⁰ minute A M.

21. I hereby certify that I attended the deceased from Jan 1936
 _____, 1936 to Mar 6, 1940
 that I last saw him alive on Mar 6, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death chr. myocarditis Duration 1936

Due to senility

Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury 1

23. Signature Frank Geary (M. D. or other) _____
 Address 1935 Park Date signed 3/6/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

L. R. Cooper
Licensed Embalmer No. 3633

P. O. Address. 2317 Legoy city

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.